

AdMIRable REVIEW

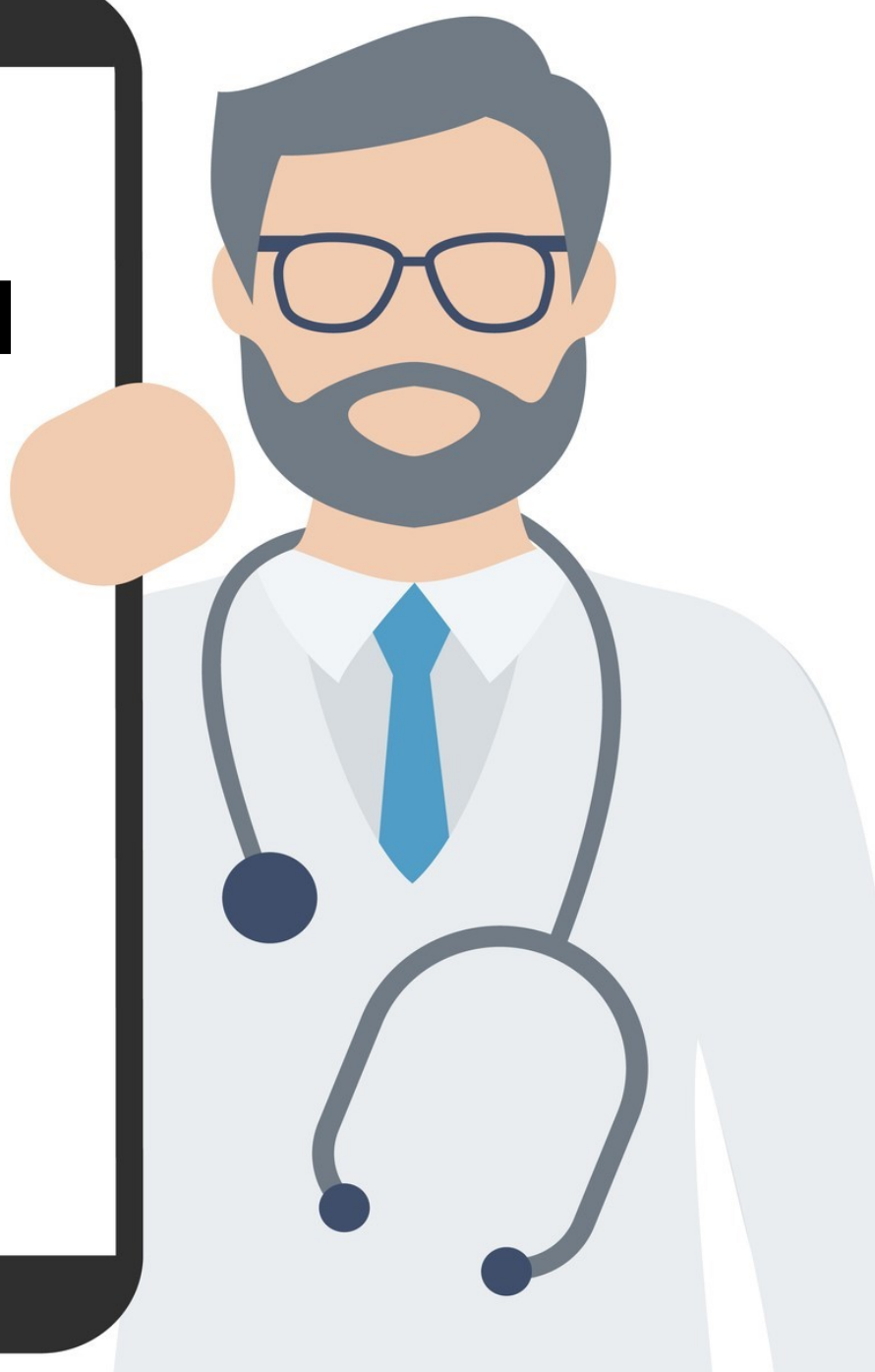
JOURNAL OF THE TENNESSEE
MEDICAL IMPAIRMENT RATING REGISTRY

VOLUME 10
Summer Issue
2021

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MIR Physician Spotlight: John J. Lochemes, MD



An active member of the MIR Registry in 2005, Dr. Lochemes is one of the most utilized MIR Physicians in the Memphis area, having issued well over one hundred MIR opinions in his career on the registry. Whenever the disputing parties choose him to perform an MIR evaluation, he applies not only this experience, but also the curiosity of a detective, the methodology of a scientist, and the craft of an artisan. "Workers' compensation injuries present a distinct challenge in orthopedics," says Dr. Lochemes. "The range of injury mechanism is broad and requires thorough investigation to best characterize and treat the injury. The greatest reward is when a patient who is treated under workers' comp brings a family member for treatment. That demonstrates confidence in your ability and trust."

Dr. Lochemes continually improves his ability to apply the *AMA Guides*, 6th Edition, by attending the Bureau-sponsored training conferences when they are offered in the Memphis area. He believes the MIR peer-review process, lead by Dr. James B. Talmage, "really enhances the overall effectiveness of the program. The administration is easy to work with. The MIR patients arrive well informed of the process and what is expected. This makes the overall evaluation more efficient. That's the biggest value of participating in the MIR system, the ability to evaluate the patients and working with the efficient administrative staff of the program. The process is streamlined, and communication is efficient and effective."

Dr. Lochemes was interested in becoming a physician at an early age. He graduated with a Bachelor of Science in Medical Sciences from the University of Wisconsin, Milwaukee, in 1984, and completed his Medical Degree at the Medical College of Wisconsin, also in Milwaukee, in 1988. Dr. Lochemes then moved to Memphis, where he completed his residency in Orthopedic Surgery at the Campbell Clinic Foundation at the University of

Tennessee. He started private practice directly after completing residency, joining Canton Orthopedics and Sports Medicine, P.C., in Canton, Georgia. While in Georgia, he served as Chief of Orthopedic Surgery and Chief of Surgery at R.T. Jones Hospital. In 1996, he joined Memphis Orthopedic Group (now OrthoSouth), where he practiced for the next 20 years until opening Titan Orthopedics, his own Clinic, centrally located in the greater Memphis area.

Dr. Lochemes feels his greatest professional accomplishment is "being able to open an

independent solo practice then finally partner with the Campbell clinic. It's a dream come true!" He treats patients of all ages, "from little leaguers on up to seniors plagued by arthritis." His mission at Titan Orthopedic is to help his patients "maintain healthy, active,



and productive lives. We've developed a reputation for quality care and personalized service." Dr. Lochemes specializes in foot and ankle conditions and arthroscopic surgery of the shoulder and knee.

A fellow of the American Academy of Orthopaedic Surgeons and the American Orthopaedic Foot & Ankle Society, Dr. Lochemes was certified by the American Board of Orthopedic Surgery in 1995 and the National Board of Medical Examiners in 1998. He is affiliated with Methodist Hospital of Memphis and Baptist Hospital of Memphis. He is also a current member of the American Academy of Orthopedic Surgery and the Memphis Orthopedic Society. He volunteers at the Church Health Center of Memphis and serves on its recruitment committee.

In his desire to be as physically active as possible, Dr. Lochemes can be found road biking on the weekends, weather permitting. Additionally, he enjoys activities with his two sons, Adam (age 25) and Andrew (age 27), especially High Performance Driving Events (HPDE), often sponsored by the National Auto Sport Association, where everyday people with high-performance cars are provided a safe environment to drive really, really fast. "The camaraderie offsets the rigors of an orthopedic practice," says Dr. Lochemes. "These events allow you to push the limits of your car and meet people from varied walks of life. You learn critical car control, which translates into better driving on public streets as well."

Dr. Lochemes' son Adam, incidentally, is the drummer and producer of the band Arlie, which was formed in 2015 and recently signed with Atlantic records. "They'll go on tour across the United States with their second album in September," says Dr. Lochemes. "Look them up!"



Certified Physician Program Arriving 2022

Jay Blaisdell, MA



As you may have heard, the Tennessee Bureau of Workers' Compensation is developing a Certified Physician Program (CPP) as part of a larger program called R.E.W.A.R.D., which is an acronym for **R**eturn **E**mployees to **W**ork **A**nd **R**educe **D**isabilities. In this issue of *AdMIRable Review*, we see clearly from Dr. Talmage and Dr. Snyder's article, *Why and How to Help Injured Workers Return to Work*, that employment has medical value for injured workers. The overall objective of the R.E.W.A.R.D. program is to reduce the number of days that injured workers are out of work, thereby

decreasing the likelihood that they will suffer from mental and behavioral disorders associated with unemployment and increasing the health advantages of being productive members of the workforce. This, in turn, helps the injured worker maintain work relationships, physical and financial independence, and mental and emotional health. It also helps lower costs associated with medical treatment, wage replacement, permanent disability, and workers' compensation. Both employees and employers have strong incentives to minimize disruption caused by workplace injuries.



Physicians Play a Critical Role in Workers' Compensation

Physicians play a vital role in the return-to-work process by establishing the expectation from the onset of treatment that the goal for the injured worker is to make a full recovery and to return to work as soon as possible. This is sometimes called "foreshadowing." Physicians who treat workers' compensation patients also perform tasks that are legally required, such as forming opinions on causation, determining the date of maximum medical improvement, and assigning permanent impairment ratings and work limitations. Unfortunately, these skills are not taught in medical school. Most physicians, except for those on the MIR Registry, have never received formal training in workers' compensation matters.

Some physicians might be reluctant to accept workers' compensation patients because these physicians are routinely asked to perform tasks for which they have not received training. The CPP is designed to teach physicians how to better fulfill their role in the workers' compensation system and the recovery and return-to-work process. The overall, long-term impact of the CPP is to reduce the friction that physicians experience working within the system, making it more appealing to practice within it and improving outcomes. Having more physicians in the system, especially those who specialize in areas of medicine that are currently underrepresented (such as pulmonologists, neuro surgeons, and ophthalmologists), improves access for injured workers to medical care, leading to fewer employee workdays missed, better health and psychosocial outcomes, lower workers' compensation costs, and fewer disability claims.

Better Training, Outcomes, and Pay

To make these desired impacts, the Bureau of Workers' Compensation would like to train and certify a broad range of physicians of various specialties and subspecialties throughout the state. Bureau-certified physicians will accept workers' compensation patients and be able to accurately assign impairment ratings, permanent work limitations, and causation opinions. They will also consistently set return-to-work expectations and goals with their patients and be able to expertly navigate the Tennessee workers' compensation system. The names of these certified physicians will be published on the Bureau's website, providing a formal reference system of workers' compensation physicians where none has existed previously. Employers and their workers' compensation insurance carriers will have access



to a formalized network of trained physicians for their injured workers. Certified Physicians, in return, will receive enhanced fees for initial workers' compensation visitations, follow-up visits, and for completing the C-30A, final medical report form. They will also feel more confident that they have the knowledge and resources to meet the challenges associated with bringing workers' compensation patients into their practices. Finally, the Bureau intends to have such a successful program that certified physicians will renew their certification every three years.

A Self-paced Online Course

The heart of the CPP is an online, self-paced certification course composed of interactive modules and examples. Training topics include determining causation and permanent impairment, navigating the Tennessee Workers' Compensation system, helping injured workers return to work, assigning maximum medical improvement and work limitations, following treatment guidelines, understanding court processes, practicing effective office and billing processes, communicating with the case manager and return-to-work coordinators, conducting independent medical examinations, and submitting utilization review appeals.

Competency will be measured with two tests, each with 50 multiple-choice questions. One test will be comprehensive while the other will focus exclusively on impairment rating methodology. Physicians may seek impairment rating certification from an approved vendor, such as the American Board of Independent Medical Evaluators (ABIME) or the International Academy of Independent Medical Evaluators (IAIME), or take and pass the Bureau's own, in-house impairment rating test.

The course material will take eight to nine hours to complete, excluding the time required for taking an *AMA Guides* impairment rating course and taking the two competency tests. Current MIR Physicians will not be required to take the impairment rating competency test to

"The heart of the CPP is an online, self-paced certification course composed of interactive modules and examples."

become certified for the CPP. Similarly, Bureau-certified physicians will have already satisfied impairment-rating training requirements for appointment to the Medical Impairment Rating Registry, should they wish to apply. Continuing Medical Education (CME) credits will be provided upon successful completion of the entire online course.

Moving Forward

The CPP is expected to be operational in 2022. If you are a physician interested in becoming certified or an employer interested in using certified physicians for your panels, the Bureau is compiling an email list to keep you apprised of the latest news regarding the CPP. Please write Jay.Blaissdell@tn.gov to receive the most recent updates regarding the CPP.

Why and How to Help Injured Workers Return to Work

James B. Talmage, MD, Robert B. Snyder, MD*



When workplace injuries cause employees to miss work, there are financial losses for the employer and employee, described by Brian Holmes in the [Fall 2019 issue](#) of the *AdMIRable Review*. The medical benefits of work for the employee were also reviewed in that same Fall 2019 issue of the *AdMIRable Review*. In the [Spring 2021 issue](#) of the *AdMIRable Review*, Jeff Francis, Assistant Administrator, introduced the new Bureau of Workers' Compensation R.E.W.A.R.D. Program that is designed to help employers help injured employees return to work. This article reviews the health benefits of reemployment to the injured worker in more and current detail.

Compounding Effects of Missed Work

When the employee is absent for a work-related injury, coworkers must take up those duties and often feel angry about it. Business productivity and morale are both affected and can be reflected in financial losses—beyond the premiums. For the employee, payment under workers' compensation does not cover all income and does not provide accumulation of other benefits such as retirement or sick leave. This can be compounded by the social isolation caused by absence from the workplace and additional home stress. All of this is additional stress on the medical condition of the injured worker beyond the medical effect of the injury itself. A lot of this may be ameliorated by returning to active work even if not at the original workplace or in a reduced capacity.

Unemployment Leads to Worse Health

A study of 1083 Swedish adults over a 14-year period concluded the longer an adult was unemployed and the cumulative total time of periods of unemployment each correlated with poorer *health* outcomes (Janlert, 2014). Herber et al. published a 10-year study of 57,911 Dutch who were working at baseline. Those who became unemployed by tax records developed poorer mental health and poorer general health (2019). Roelfs et al. published a systematic review of 42 studies with 235 independent calculations of mortality in 20 million people and found becoming unemployed in early or mid-career resulted in an increase in death rate very similar to the increased death rate in smokers (2011).

Reemployment Associated with Improved Health

Rueda et al (2012) published a systematic review of 18 studies on return to work versus continued unemployment and found:

RESEARCH DESIGN:

When physicians study treatment options to find the best treatment for diseases or injuries, the best study design is the **Randomized Controlled Trial**, as randomization assures the groups receiving different treatments are very similar, and thus the outcomes comparisons are valid.

A **systematic review** is a publication whose authors searched multiple databases to find all relevant and methodologically sound published studies on a topic.

Fifteen studies revealed a beneficial effect of returning to work on health, either demonstrating a significant improvement in health after reemployment or a significant decline in health attributed to continued unemployment. Some evidence suggested that earlier reemployment may be associated with better health.

Carlier et al published an 18-month study of 4308 unemployed Dutch citizens. Those becoming reemployed had improvements in self-reported quality of life and good health, compared to those who remained unemployed (2013). The 2017 summary of the health benefits of work for the employee was written by the Australia and New Zealand physicians' Royal College of Medicine. This 2017 Consensus Statement includes the following statements:

- The provision of good work is a key determinant of the health and wellbeing of employees, their families, and broader society.
- Long term work absence, work disability, and unemployment may have a negative impact on health and wellbeing.
- With active assistance, many of those who have the potential to work, but are not currently working, can be enabled to access the benefits of good work.
- Good outcomes are more likely when individuals understand and are supported to access the benefits of good work especially when entering the workforce for the first time, seeking re-employment, or recovering at work following a period of injury or illness.

Modified Employment Helps

Viikari-Juntura et al studied adult workers with musculoskeletal disorders who were unable to do their jobs (2012). They were randomly assigned to full time sick leave or to modified duty with a reduction in work hours and if needed work tasks. Workers in the modified duty group returned to sustained full-duty work sooner and had a lower number of total sickness absence days over the next 12 months. The same authors later reported that modified duty resulted in better self-rated general health, and health related quality of life (Shiri, 2013). Van Duijn and Burdorf (2008) stated that studies show workers who have modified duty after injury return to work sooner than those who stay off work until able to return to full duty. They then studied whether modified duty affects the rate of recurrence of musculoskeletal disorders. Workers who performed modified duty had a lower rate of recurrence of their disorder over the next 12 months. A formal employer plan to return injured workers to work and employer support of the worker returning to work have been shown to be associated with better return to work outcomes (Gray, 2019).

“Workers who performed modified duty had a lower rate of recurrence of their disorder over the next 12 months.”

The R.E.W.A.R.D. Program

The focus of the TN BWC [R.E.W.A.R.D.](#) program assists employers in helping injured workers return to the fullest possible employment. Permitting modified duty is one of the ways employers can help injured workers achieve improved overall health outcomes. Modified

duty during recovery is in the injured employee's best interest for their overall health and wellbeing. This is a one reason why the Tennessee BWC published the R.E.W.A.R.D. Toolkit. The "Toolkit" for employers is on the BWC [website](#).

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*Guest Contributor Robert B. Snyder, MD

Dr. Snyder was appointed Medical Director for the Bureau of Workers' Compensation in January, 2014 after 37 years of Orthopaedic private practice. A graduate of Wayne State University School of Medicine in Detroit, he completed two years of general surgery training at the University of Pittsburgh before coming to Nashville to complete a residency in Orthopaedics and Rehabilitation at Vanderbilt University. His activities with the Bureau

include Medical Treatment Guidelines, the Drug Formulary, Utilization Review, Case Management, Fee Schedules and physician/provider communication .Dr. Snyder has presented lectures for the American Academy of Orthopaedic Surgeons, Arthroscopy Society of Peru, the American Orthopaedic Society for Sports Medicine, the National Workers Compensation and Disability Conference, the National Association of Workers Compensation Judges, and in Tennessee: the Tennessee Chiropractic Association, the Tennessee Orthopaedic Society, the Tennessee College of Occupational and Environmental Medicine, the Tennessee Pain Society, the Tennessee Neurosurgical Society, the Tennessee Medical Society, and Tennessee Attorney Memo.



Telerehabilitation: Challenges and Benefits

Dan Headrick PT, CEAS III, Astym Cert., CETS, BS*



Over this last year, I have had the honor of witnessing physical and occupational therapists embrace and utilize telerehab to continue therapy services, trying to help injured workers avoid surgery, rehabilitate from surgery, lessen the use of opioids for painful musculoskeletal conditions, and avoid additional medical procedures due to not healing properly. Therapists have walked alongside patients who feared for the safety of themselves and their families when attending live therapy sessions, creating an effective virtual rehabilitation environment.

Telerehab, while not a fully comparable choice to in-clinic services, became the only rehab choice for some patients. Therapists had to think creatively to provide this type of care, keeping the relational in-person component so vital to healing and restoration in a virtual setting. Additionally, therapists donned dual hats when treating, becoming technology assistants as well as rehabilitative professionals. As patients and therapists have worked through this treatment option, the challenges and benefits of telerehab, described below, have become more apparent.

Challenges of Telerehab

The challenges in telerehab can be broken into four areas: assessment, treatment, technology and patient status, and outcomes.

The first challenge, assessment, occurs at the beginning, end, and throughout the therapy process. Payer sources require objective testing to establish the medical necessity of therapy services. Therapists use various testing processes to objectively assess function, movement, and the underlying causative restrictions in joints and muscles that impair patients. Among the testing processes is goniometry. Apps such as RateFast Goniometer have helped establish virtual motion testing, as well as using body landmarks for motion assessment. Though studies are slow in confirming the accuracy of these measurement methods, both the technology and therapist ability to work with it are improving.

Likewise, standardized mobility assessments and work testing can be complex. Standardized functional mobility testing assumes a level of balance and ability that is difficult to assess without trained supervision of the client to ensure safety. Trusting patient guarding to an untrained family member is not medically safe when balance dysfunction is present. Work testing, such as job-specific material handling, is an additional assessment component that cannot be done in a virtual setting. Finally, manual joint and muscle testing, hands-on assessment of joint restrictions, trigger points and muscle reactivity to pain, all integral in improving motion and function, cannot be done remotely.

A second challenge revolves around an incomplete treatment program. Due to limitations in assessment ability in manual testing and standardized functional assessments, formulated treatment plans can be incomplete, lengthening total rehab time. Further, treatment can be unsafe for clients with balance issues.

Third, technology and patient status can be an insurmountable barrier. Clients with no internet access, and limited access to technology devices that are required to implement a telerehab session, will need clinical services. A client who is not compliant or has a limited cognitive status will have difficulty excelling in a virtual rehab environment.

The fourth hurdle to overcome is not realized until the end of the treatment sessions. Patient outcomes can be negatively impacted. Injured workers who receive only virtual services lose hands-on skilled care necessary to improve active movement. Some clients do not push themselves for fear of injury. Lessening range of motion outcomes can worsen impairment ratings, increasing system costs and diminishing return-to-work ability.

Benefits of Telerehab

Clients who live in remote areas, have internet access, do not have impaired balance or require hands-on care (for safety or improving motion or function,) and are compliant in their medical care, could be good candidates for telerehab services. Such candidates can receive many benefits from utilizing telerehab services, including home environment assessment and safety training, pain and symptom checks (to avoid unnecessary ER or medical visits), and enhanced compliance with therapist-prescribed home exercises despite regular pain occurrences. Patients often overreact to typical pain progressions. Telerehab can be a vital tool to address their fears and keep them moving. For immediate post-op patients experiencing nausea and pain symptoms, making it difficult for them to get to a clinical setting, telerehab can help until the patient is able to enter a clinical setting. Finally, travel costs and mileage reimbursement are eliminated with virtual sessions.



Conclusion

Considering both the challenges and benefits for virtual therapy, would a combination of these services, both live and virtual provided concurrently, produce better outcomes for the injured worker? Current evidence cannot support an accurate answer to that question. However, combining evidence-based clinical services, where hands-on treatments are being used to facilitate healing, with the convenience and accountability of the virtual environment, appears to be a viable option. When this hybrid approach is utilized with the appropriate candidate, the benefits of both systems are realized, likely producing a better outcome in patient functional ability and case cost.

***Guest Contributor Dan Hendrick PT, CEAS III, ASTYM, BS**

Dan Hendrick has been a physical therapist since 1992 and is a Level II and III Certified Ergonomic Assessment Specialist. He has been a presenter at the Tennessee Bureau of Workers' Compensation (BWC) Physician Education Conference and the Bureau's annual education conference. He is married to his college sweetheart of twenty-seven years and has two "fantastic adulting children," and one "cute rescue."

The Role of Other Medical Disciplines in Workers Compensation: Case Law

Jane Salem, Esquire



Medicine, like so many other professions and businesses these days, seems to have adopted a team approach to patient care. Workers' compensation is no exception. Injured workers often see many providers when treating, from disciplines other than medical doctors.

Tennessee law has clarified the proper roles of these other providers. The common theme is they *support* the physicians but don't supplant them. The statute contemplates medical doctors and chiropractors making the major decisions.

For example, as to compensability, the Workers' Compensation Law states that an injured worker must show that the injury arose primarily out of employment, and this must be shown "to a reasonable degree of medical certainty," that the employment contributed more than 50% in causing the injury. This means, generally speaking, that medical doctors must provide causation opinions for the judges' consideration (except in obvious cases, e.g., a worker accidentally amputates a finger while operating a power saw at work).

Moreover, under the statute panels must list "physicians, surgeons, chiropractors or specialty practice groups." No other category of provider is listed. As to impairment ratings they are assigned by "the treating physician or chiropractor."

Nurses, Nurse Practitioners, Physicians Assistants

In the 1990s, the Division [now Bureau] of Workers' Compensation implemented rules for "case managers" typically registered nurses with advanced education or certifications. The development of nurse/case managers represented an advancement for the role of some nurses in workers' compensation.

The current iteration of rules for case managers states that, among their duties, they may develop treatment plans, monitor the treatment progress of the injured employee, assess whether alternate medical care services are appropriate, ensure that the injured worker is following the prescribed medical care plan, and formulate a plan for return to work.

But the rules are also very specific regarding what a case manager *cannot* do. Among the activities that a case manager "shall not" do are:

- Prepare the panel of physicians, or influence the employee's choice of physician.
- Discuss with the employee or physician what the impairment rating should be.
- Determine whether the case is work related.
- Question the physician or employee regarding issues of compensability.

The last two prohibitions mirror a Tennessee Court of Appeals ruling from 2008. In *Hinson v. Claiborne & Hughes Health Ctr.*, plaintiffs alleging a wrongful death presented evidence from a registered nurse. She testified via affidavit that she was familiar with the standard of care at nursing homes and, in her opinion, the care an elderly patient received fell below it. The nurse further stated that his ultimate death was “more likely than not directly impacted” by the failures of this particular nursing home.

The appellate court concluded, with little discussion, that, “A nurse is not an expert who can testify as to medical causation.”

Fast-forward to 2015, where the Tennessee Workers’ Compensation Appeals Board cited *Hinson* to conclude that *nurse practitioners* (not nurses) can’t give causation opinions.

In *Dorsey v. Amazon.com*, the injured worker never saw a medical doctor. Rather, a nurse practitioner evaluated her and gave the opinion that her condition wasn’t work-related. The employer denied the claim based on that opinion.

The Appeals Board held that this was an invalid basis for denial. The medical records didn’t contain an opinion from a physician regarding causation, the Board reasoned. The opinion of the nurse practitioner “did not and could not provide a valid basis for denial of the claim based on causation.”



Administrative rules echo this and state additional prohibitions.

Specifically, nurse practitioners, physician assistants, and “other mid-level practice extenders under the supervision, direction and ultimate responsibility of a licensed physician,” may provide treatment ordered by the attending physician “in accordance with their licensing.” However, “only the supervising physician . . . listed on an Employee Choice of Physician Form C-42 may determine medical causation regarding the injury, may issue a permanent impairment rating, and may determine the date of an injured employee’s maximum medical improvement.”

Physical and occupational therapists

In a 1991 opinion, *Bolton v. CNA Insurance*, an employer argued that a trial court incorrectly assigned a sizeable vocational disability, considering a vocational expert who relied on the opinions of a physical therapist.

In the case, the employee injured his neck and back at work. An authorized physician ultimately assigned a three to five percent permanent partial impairment, but he placed no restrictions. The employee's attorney then referred the injured worker to a physical therapist for evaluation.

The physical therapist performed tests and determined that the worker had limitations in cervical and lumbar motion. She testified, over objection, that she used the *AMA Guides* to assign a total whole-body impairment rating of 18 percent. She further testified, also over objection, that she placed physical restrictions.

The Supreme Court reversed, holding that a physical therapist "is not qualified to form and express an expert opinion as to the permanent impairment or permanent physical restrictions of an injured person."

The justices wrote: "[A] physical therapist's testimony must be limited to objective findings and cannot encompass an opinion on ultimate disability. As a result, that part of the vocational expert's opinion which was solely based on the opinions of the physical therapist as to permanency and physical restrictions was inadmissible evidence."

But the high court noted that nothing limits a physical therapist from making future physical activity recommendations to the referring physician or a patient, based on the results of tests performed within the scope of the physical therapist's licensure. Physical therapists may also testify on those matters.

A few years later, a Supreme Court Panel relied on *Bolton* to reach a similar conclusion regarding occupational therapists in *La-Z-Boy, Inc. v. Van Winkle*.

In the case, an occupational therapist testified about the purpose of carpal tunnel release surgery. He also gave a detailed explanation of nerve regeneration and said, "It was my opinion that the first FCE was ordered a little too early."

The Panel held that the occupational therapist was giving an improper "medical" opinion. It cited *Bolton* for the proposition that physical therapists must give testimony concerning matters within their licensure. So, too, must occupational therapists.

Conclusion

Providers other than medical doctors often play varied and vital roles in workers' compensation cases. But generally speaking, the law requires that they remain within their training and licensure. Stated another way, from the legal perspective at this time, providers within other disciplines *help* medical doctors to offer appropriate and cost-effective care. But they remain in a supportive role.

Whether that will change in the future is unknown.

AdMIRable Review Editorial Staff

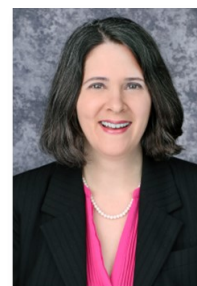
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